HL7 Application

Practice/Provider Name _____

Point of Contact:

Name: _____

Title: _____

Phone: _____ Fax: _____

Email: _____

Provider Information:

Type of Provider: circle one

Pharmacy Pediatrics General Practice

Health Department Hospital Urgent Care

Number of patients you serve: _____

Number of clinics (if applicable) _____

Please list clinics: _____

_____

_____

_____

_____

What is the address of the main office? _____

_____

_____

Electronic Medical Record:

What is the name of your EMR system _____

_____

Is historical immunization data entered into your EMR? **YES or NO**

Do you have onsite IT personnel? **YES or NO**

If yes does that professional have data exchange experience? **YES or NO**

Current Workload:

Can you assign an IT resource for 6 months? **YES or NO**